



PRESCRIPTION MEDICATION REPORT

Licensee: Fill in your name, your phone number, and mark the appropriate box below. The prescribing practitioner is required to complete the remainder of the form. Once the form is completed, the practitioner must return the form to ArNAP staff no later than **ten (10) days** after your visit, or **twenty-four (24) hours** prior to the date of the procedure/surgery.

Practitioner providing medical treatment to Licensee: Please complete the form below. Once completed, please return to ArNAP staff by fax, email, or mail. If you have any questions, please contact ArNAP staff.

Licensee _____ Phone _____ or ArNAP Assistant Director: **Tonya S. Gierke, Assistant Director, ArNAP** Phone: 501-683-0016

Date	Method Given (Check all that apply)	Medication	Dosage, Route, Frequency	Number dispensed	Number of refills	Reason for Medication	Expected Length of Treatment	Detox Plan (If necessary)
	<input type="checkbox"/> Administered in office <input type="checkbox"/> Sample(s) given <input type="checkbox"/> Prescription given <input type="checkbox"/> Prescription called in to Pharmacy							
	<input type="checkbox"/> Administered in office <input type="checkbox"/> Sample(s) given <input type="checkbox"/> Prescription given <input type="checkbox"/> Prescription called in to Pharmacy							
	<input type="checkbox"/> Administered in office <input type="checkbox"/> Sample(s) given <input type="checkbox"/> Prescription given <input type="checkbox"/> Prescription called in to Pharmacy							
	<input type="checkbox"/> Administered in office <input type="checkbox"/> Sample(s) given <input type="checkbox"/> Prescription given <input type="checkbox"/> Prescription called in to Pharmacy							

I understand that this patient has entered into a contract with the Arkansas Nurses Alternative to Discipline Program (ArNAP) to abstain at all times from the use of controlled or abuse potential substances, including alcohol and products that contain alcohol. Short-term treatment of an acute episode will be acceptable with documentation that no other reasonable medical alternative is available. Short-term treatment is a course of treatment that is limited in duration (less than three weeks).

Practitioner Signature

Practitioner Name (Please print)

Office Phone Number

Date